28
S. No. 2
M—2-43
5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33550

FILED NOV 10 1943 318 1003

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 9539

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 Days
(Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED: 000 17 9 20

(a) State MO (b) County _____

(c) City or town ST LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 2317 SULLIVAN AVE
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Margaret Shohence

3. (b) If veteran, name war —

3. (c) Social Security No. _____

4. Sex FEMALE | 5. Color or race WHITE | 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Unknown (Month) 1880 (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
63	unknown		hr. min.

9. Birthplace Mo (City, town, or county) 0 (State or foreign country)

10. Usual occupation —

11. Industry or business _____

FATHER
12. Name Shohence
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name " "
15. Birthplace " (City, town, or county) 9 (State or foreign country)

16. (a) Informant Richard Flood
(b) Address 2317 Sullivan ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 30 43 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Central Funeral
(b) Address 1841 Cass ave

19. (a) OCT 30 1943 (Date received by local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 28, year 1943 hour 2:15 P. minute _____ M.

21. I hereby certify that I attended the deceased from October 22, 1943 to October 28, 1943; that I last saw h... or... alive on October 28, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral arteriosclerosis (Softening of the brain)	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Primary tuberculosis, moderately advanced	

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature Frank H. Kimberg (M. D. or other) M.D.
Address 1515 Lafayette Avenue Date signed 10/29/43

(Licensed Embalmer's Statement on Reverse Side)

BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed John Agonoska

Licensed Embalmer No. 3398

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. No. 2B
M—5-43
o I X36930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Mar.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 9539

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town _____ (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hosp.

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 da (Specify whether —, years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Margaret Shokence

3. (b) If veteran, name war — 3. (c) Social Security No. —

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Aug. (Month) 16 (Day) 1880 (Year)

8. AGE: Years 63 Months — Days — If less than one day, hrs. — min.

9. Birthplace _____ (City, town, or county) Mo. (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

FATHER
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

MOTHER
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) NOV 15 1943 (Date received local registrar) J. F. Bredeen (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct. day 15 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw h_____ alive on _____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death _____	
Due to _____	
Due to _____	
Other conditions _____ (Include pregnancy within 3 months of death)	

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

33550